



**KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT  
BOARD OF ADULT CARE HOME ADMINISTRATORS  
RECIPROCITY LICENSURE QUESTIONNAIRE**

APPLICANT: PLEASE MAKE COPIES OF THIS FORM AS NEEDED

An applicant who is licensed in another state as an adult care home administrator may be considered for licensure in Kansas upon determining that the applicant met licensing standards in other states that were not less than those standards for licensure in Kansas on the date of original licensure. To establish eligibility for licensure, this questionnaire must be completed by the applicant and licensing agency in each state in which a license was or is currently held.

**Part I - Applicant:** Complete, sign and date Part I of this application; forward it to the licensing agency in the state where you are/were licensed.

Name \_\_\_\_\_

Present Address \_\_\_\_\_

Name which appears on license, if different \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

State in which licensed \_\_\_\_\_ License No. \_\_\_\_\_

I hereby give permission to the authorized officer with the \_\_\_\_\_<sup>(State)</sup> licensing agency to divulge examination scores and other information pertinent to my adult care home administrators license issued by that state.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

**Part II - State Licensing Agency:** Please complete this section concerning the administrator named above. Do your records agree with the information in Part I ☐ YES ☐ NO

If "No", please explain: \_\_\_\_\_

Date License was issued \_\_\_\_\_ Expiration date \_\_\_\_\_

Was your state the state of original licensure? ☐ YES ☐ NO

If "No", which state is indicated as the state of original licensure? \_\_\_\_\_

Which written licensing examination did the applicant take?  
PES \_\_\_\_\_ NAB \_\_\_\_\_ Other \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr.

Total raw score \_\_\_\_\_ Scaled score \_\_\_\_\_

Effective July 1, 1990, was applicant required to complete:

➤ a long-term care administrator practicum approved by an accredited college or university?  
☐ YES ☐ NO If "Yes", please state length of program \_\_\_\_\_

➤ a long-term care administrator internship approved by a state board?  
☐ YES ☐ NO If "Yes", please state length of internship \_\_\_\_\_

Over

Is the applicant in good standing with your board at this time?

☐

YES

☐

NO

If "No", please explain \_\_\_\_\_  
\_\_\_\_\_

According to your records, has the applicant ever been disciplined by your board or other state agency?

☐

YES

☐

NO

If "Yes", please explain \_\_\_\_\_  
\_\_\_\_\_

According to your records, has the applicant every been convicted of a crime by any court in the state of \_\_\_\_\_,

any court of any other state, or any federal court of the United States?

☐

YES

☐

NO

Do you favorably recommend the above applicant to be licensed by reciprocity by the State of Kansas?

☐

YES

☐

NO

Additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(PLACE SEAL HERE)

Please return this form to:

**Health Occupations Credentialing  
Kansas Department of Health and Environment  
1000 SW Jackson, Suite 200  
Topeka KS 66612-1365**

Signature \_\_\_\_\_

Title \_\_\_\_\_

Agency \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_